WISCONSIN MEDICAID
FEDERALLY QUALIFIED HEALTH CENTER COST REPORT COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Non-submission of cost report data will result in no settlement determination being made.

Completion instructions for the following federally qualified health center (FQHC) cost report forms are included in this document:

- Federally Qualified Health Center Certification Statement.
- Federally Qualified Health Center Statistical Data Worksheet.
- Federally Qualified Health Center Reclassification and Adjustment of Trial Balance of Expenses; Worksheet 1.
- Federally Qualified Health Center Staff, Encounters, Productivity, and Charges; Worksheet 2.
- Federally Qualified Health Center Determination of Overhead, Rate, and Reimbursement; Worksheet 3.
- Federally Qualified Health Center Managed Care Income Reporting; Worksheet 4.
- Federally Qualified Health Center Outstationed Eligibility Expenses; Worksheet 5.

The FQHC worksheets provide necessary administrative and financial information and delineate the rate calculation process. The use of these forms is voluntary, but providers are required to submit the information required on the forms for a settlement determination and payment to take place.

Failure to comply with the terms of these completion instructions and associated forms or the regulations of Wisconsin Medicaid can result in penalties. Serious violations in compliance can result in temporary termination of the FQHC's eligibility for this benefit.

All statements in these completion instructions and associated forms are subject to further clarification and interpretation by the Centers for Medicare and Medicaid Services (CMS), the Public Health Service (PHS), or the Indian Health Service (IHS). If at any time Wisconsin Medicaid receives notification from the CMS, PHS, or IHS contradicting, clarifying, or adding to the content of these completion instructions, associated forms, Terms of Provider Reimbursement, or Provider Agreement, the FQHC will be notified of the changes.

SUBMITTING COST REPORTS

Wisconsin Medicaid FQHCs interested in receiving a cost settlement for services rendered to Medicaid and BadgerCare recipients for a given fiscal year are required to file a cost report with Wisconsin Medicaid. Cost reports will be accepted if they are submitted within five years of the last date of service (DOS) in the fiscal year. If a cost report is not completed and submitted to Wisconsin Medicaid within five years of the DOS, providers will not receive a cost settlement.

Cost reports should be submitted by mail to the following address:

Wisconsin Medicaid
Bureau of Health Care Program Integrity
FQHC Auditor
PO Box 309
Madison WI 53701-0309

The FQHC is responsible for assuring that the Federally Qualified Health Center Certification Statement is signed before the cost report is submitted and that the Wisconsin Medicaid FQHC Auditor receives the cost report after it is submitted.

Interim reports may be filed during the current year to streamline cash flow using the Federally Qualified Health Center Interim Report, HCF 11130 (Dated 03/06). Interim payments made by Wisconsin Medicaid to FQHCs are subject to recoupment if a cost report is not filed for the fiscal year in question. Interim payments made by Wisconsin Medicaid to FQHCs are also subject to recoupment at the time of annual cost settlement calculation if the sum of payments exceeds the annual cost settlement calculation. Federally qualified health centers are encouraged to make conservative estimates in their interim requests.

In completion of the cost report, the FQHC must comply with all the requirements and limitations stated in the Provider Agreement, Terms of Provider Reimbursement, and all applicable Medicaid publications. Wisconsin Medicaid retains the right to establish limits on the FQHC rate of payment.

Additional information may be attached to the cost report, if necessary.

COST REPORT FORMS

All FQHCs are required to complete certain cost report forms. These forms are required for the determination of a Medicaid rate of payment of reasonable costs as required by Sections 1905(a)(2)(C) and 1902(bb) of the Social Security Act. The principles of reasonable costs are determined in 42 CFR Part 413. Allowable cost information is contained in Health Insurance Manual 15.

All FQHCs are required to complete the following cost report forms:

- Federally Qualified Health Center Certification Statement.
- Federally Qualified Health Center Statistical Data Worksheet.
- Federally Qualified Health Center Reclassification and Adjustment of Trial Balance of Expenses; Worksheet 1.
- Federally Qualified Health Center Staff, Encounters, Productivity, and Charges; Worksheet 2.
- Federally Qualified Health Center Determination of Overhead, Rate, and Reimbursement; Worksheet 3.

In addition, FQHCs that have fiscal arrangements with Medicaid HMOs or Medicaid managed care organizations should complete the Federally Qualified Health Center Managed Care Income Reporting; Worksheet 4.

The Federally Qualified Health Center Outstationed Eligibility Expenses; Worksheet 5 should only be completed by FQHCs that employ or contract staff who assist applicants with the Medicaid eligibility determination process.

All information provided by the FQHC is subject to review and approval by Wisconsin Medicaid and is subject to audit. If necessary, limited assistance in completion of these forms will be provided by the FQHC Auditor.

DETERMINATION OF THE ENCOUNTER RATE

The cost report forms are used to determine the encounter rate. To determine the encounter rate, total allowable costs (after adjustments) are divided by total provider encounters to arrive at the allowable cost per encounter.

An encounter is defined as a face-to-face contact for the provision of a medical service between a recipient and a single Medicaid-certified provider on a single day, at a single location, for a single diagnosis or treatment. Federally qualified health centers may not count visits by providers who may not be separately certified by Wisconsin Medicaid, such as registered nurses, licensed practical nurses, medical assistants, dental assistants, or dental hygienists.

An FQHC is paid the encounter rate for each Medicaid recipient encounter minus any payments received by the FQHC from Medicaid (including any interim payments, payments from Medicaid HMOs, and payments from Medicaid fee-for-service claims), Medicare (for dual eligibles), and when required, the Medicaid recipient's copayment and any third party payments. Federally qualified health center services provided to Medicaid HMO enrollees do not require copayments.

Multiple contacts of a recipient with the same health professional that occur on the same day, at a single location, for the treatment of the same health condition or diagnosis constitute a single encounter unless the recipient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

When the recipient is an inpatient, such as in a hospital or nursing home, only one encounter per day, per recipient, per provider may be charged. An inpatient is required to be a previously established FQHC patient who is not permanently residing in the hospital or nursing home. The FQHC may continue to charge for visits only if it is determined that the inpatient will be leaving the hospital or nursing home and resuming services at the FQHC.

All Medicaid-covered services provided to Medicaid-eligible recipients must be provided by one of the affiliated FQHC provider types that are listed on the Federally Qualified Health Center Statistical Data Worksheet under Elements 8, 9, and 10. Services for Medicaid recipients must be provided by Medicaid-certified providers. Claims for those services must be submitted to Wisconsin Medicaid (or a Medicaid HMO) and paid to be considered an encounter.

Only those services that are defined as FQHC reimbursable may be included as allowable costs. In conformance with Medicaid policy, the determination of the encounter rate is designed to eliminate the portion of overhead and costs that are not attributable to Medicaid-eligible services. Using this determination, the portion of costs allowed is based on the percent of total encounters furnished by Medicaid-certified providers at the FQHC. Costs are also adjusted for those costs that are disallowed under Wisconsin Medicaid, including costs that are unreasonable.

The following services will not be counted as encounters by the FQHC, but are eligible for reimbursement independent of the FQHC by Medicaid fee-for-service:

- Services that are provided to a patient on any basis by any provider, including FQHC employees and contracted staff if the cost or liability for that service is not borne by the FQHC.
- Any services provided to FQHC patients through referral to a provider in which the FQHC has no contractual relationship with the provider and the funding for the services is not borne by the FQHC.
- Reference laboratory services.

FEDERALLY QUALIFIED HEALTH CENTER CERTIFICATION STATEMENT

SECTION I — PROVIDER AND PREPARER INFORMATION

Enter the name of the FQHC and the FQHC's Medicaid provider number. Enter the name, title, telephone number, and fax number of the person preparing the cost report. This information will enable Wisconsin Medicaid to contact the person preparing the cost report in the event that further information or clarification of the cost report is required. Enter the inclusive dates of this cost report.

SECTION II — CERTIFICATION AND SIGNATURE

The Certification Statement must be signed after the cost report has been completed in its entirety. The individual signing the Certification Statement is required to be an officer or administrator of the FQHC.

FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA WORKSHEET

SECTION I — PROVIDER INFORMATION

Elements 1 — 3
Enter the name, Medicaid provider number, and address of the FQHC.

Element 4 — Type of Organizational Structure
Indicate the FQHC's type of organizational structure.

Element 5 — FQHC Owner
Enter the name of the organization or individual who is the legal owner of the FQHC. If the FQHC is controlled by a nonprofit organization, enter this information and state the name of the nonprofit organization's chairperson.

Element 6 — Reporting Period
Enter the inclusive dates of this cost report.

SECTION II — OTHER ENTITIES OF THE FQHC OWNER

Element 7
List all other FQHCs and providers of services including rural health clinics, hospitals, skilled nursing facilities, home health agencies, suppliers, or other entities that are owned or related through common ownership or control to the individual or entity listed in Element 5.

At the FQHC's discretion, additional Medicaid provider numbers for multiple FQHC clinics may be obtained for billing for FQHC services at the other clinics. If the FQHC has multiple locations with different Medicaid provider numbers, list those clinics.

SECTION III — PHYSICIANS DIRECTLY EMPLOYED BY THE FQHC

Element 8
List the Medicaid-certified physicians furnishing services at the FQHC who are directly employed by the FQHC. Include all National Health Service Corporation federal hires in this element.

SECTION IV — OTHER PROVIDERS DIRECTLY EMPLOYED BY THE FQHC

Element 9
List any other Medicaid-certified providers furnishing services at the FQHC who are not physicians but are directly employed by the FQHC.

SECTION V — PHYSICIANS AND OTHER PROVIDERS UNDER CONTRACT WITH THE FQHC

Element 10
List the Medicaid-certified physicians and other providers furnishing services at the FQHC who are under contract with the FQHC.

SECTION VI — OTHER FQHC MEDICAID PROVIDER NUMBERS

Element 11
List any Medicaid billing provider numbers included in the FQHC's expenses (e.g., mental health services, substance abuse services, case management services), excluding the Medicaid provider number listed in Element 2.

FEDERALLY QUALIFIED HEALTH CENTER RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES; WORKSHEET 1

Federally qualified health centers are required to submit the trial balance expense account information requested on this worksheet from the FQHC's accounting books and records. All reporting must be made on an accrual basis. Expenses should be reported using the audited trial balance unless the FQHC is submitting a budgeted cost report. When submitting a budgeted report, reasonable and supportable estimates should be used. The worksheet also provides for any necessary reclassification and adjustments to these accounts.

Not all of the listed cost centers will apply to each FQHC. For example, an FQHC might not employ radiology technicians and would not, in that case, complete Line 20.

Medical services that are incident to physician, physician assistant, nurse practitioner, clinical social worker, or clinical psychologist services should be accounted for under indirect costs.

Dollar amounts may be rounded to the nearest whole dollar.

SECTION I — GENERAL INFORMATION
Enter the FQHC's Medicaid provider number and the inclusive dates of this cost report. Indicate whether the reported expenses are estimated or from the audited trial balance.

SECTION II — FACILITY HEALTH CARE COSTS

COLUMNS A-E — TRIAL BALANCE OF DIRECT EXPENSES
The expenses listed in Columns A through E must be in accordance with the FQHC's accounting books and records for historic cost reports. Budgeted cost reports must be based on soundly based projections.

Enter the total expenses incurred or budgeted for the period of the report on the appropriate lines in columns A through E. The expenses must be detailed between Compensation (Column A), Fringe Benefits (Column B), Purchased and Contract Services (Column C), and Other (Column D). The sum of columns A through D must equal Column E. Any reclassifications and adjustments must be recorded in Columns F and H, as appropriate.

To the extent possible, amounts listed on Worksheet 1, Columns A through D and/or the Total in Column E should agree with the FQHC's audited trial balance. If the FQHC's trial balance is in a format that does not conform with the format of Worksheet 1, a separate bridging worksheet must be prepared which shows how the amounts reported on Worksheet 1, Columns A through D were determined. The bridging worksheet must be retained by the FQHC and, upon request, be made available to Wisconsin Medicaid for review.

COLUMN F — RECLASSIFICATIONS
Column F is used to reclassify expenses among the cost centers for proper grouping of expenses. One manner in which reclassifications are used is in instances when the expenses applicable to more than one of the cost centers listed on the worksheet are maintained in the FQHC's accounting books and records in one cost center.

For example, if a physician performs some administrative duties, the appropriate portion of his or her compensation, and applicable payroll taxes and fringe benefits, would need to be reclassified from the primary provider cost center to the overhead cost center. Supporting documentation explaining the reclassifications may be provided by the FQHC with the completed cost report. Reductions to expenses should be shown in brackets [ ]. The net total of the entries in Column F must equal zero.

COLUMN G — RECLASSIFIED TRIAL BALANCE
Enter the sum of Columns E and F. The net balance for each line is entered in Column G. The total of Column G on Line 66 of this worksheet must equal the total of Column E on Line 66 of this worksheet.

COLUMN H — ADJUSTMENTS
Enter the amount of any adjustments to the FQHC's reclassified expenses. Adjustments may be required to increase or decrease expenses in accordance with the Medicare and Wisconsin Medicaid rules on allowable costs. Examples of situations in which adjustments to expenses may be required include the following:

- The FQHC has transactions with a related organization.
- The FQHC receives restricted grants and gifts.
- The FQHC depreciates assets on other than an acceptable basis, recognized by Medicare or Wisconsin Medicaid.
- The FQHC receives an allocation of cost from a home office.
- The FQHC has a practitioner assigned by the National Health Service Corps.
- The FQHC incurred costs for services that would *not* be eligible for Medicaid reimbursement, whether they are for a Medicaid recipient or not.
- The services are not eligible for reasonable cost reimbursement; e.g., contract health costs for tribal clinics.
- The revenues directly reduce expenses; e.g., a rent receipt for space for which costs are reported as expenses or interest income to offset reported interest expense.
- The costs from the trial balance of outstationed eligibility workers that were reported in columns A through D that must be deducted from Worksheet 1 and reported on Worksheet 5, where they are reimbursed at 100 percent.

Decreases to expenses are to be shown in brackets [ ].

A worksheet explaining the adjustments shall be provided by the FQHC with the completed cost report.

COLUMN I — NET EXPENSES
Enter the sum of Columns G and H. The net balance of each line item is entered in Column I.

FEDERALLY QUALIFIED HEALTH CENTER STAFF, ENCOUNTERS, PRODUCTIVITY, AND CHARGES; WORKSHEET 2

Worksheet 2 is used to record the full-time equivalent (FTE) medical services personnel devoted to the provision of medical services and to summarize the number of FQHC encounters to Medicaid recipients or non-Medicaid patients furnished by these personnel.

Statistics on encounters in which the services provided are not eligible for Medicaid reimbursement should be excluded. Full-time equivalent personnel time devoted to tasks other than medical services should also be excluded.

SECTION I — GENERAL INFORMATION
Enter the FQHC's Medicaid provider number and the inclusive dates of this cost report. Indicate whether the reported expenses are estimated or from the audited trial balance.

SECTION II — STAFF AND ENCOUNTERS

Lines 1-17
Lines 1-17 should be used to record the FTE personnel and encounters of the Medicaid-certified providers who perform services for the FQHC reporting on Worksheet 1, Column I, Lines 1-17.

Full-time equivalent staff are defined as Medicaid-certified staff who provide 470 half days (approximately 4 hours per day) of recipient services in a year. Do not include administrative services.

FULL-TIME EQUIVALENT PERSONNEL

Column A
List the number of FTE personnel that are not employees of the FQHC, but are under agreement or contract with the FQHC to provide recipient services.

Column B
List the number of FTE personnel that are employees of the FQHC.

Column C
Enter the sum of Columns A and B.

ENCOUNTERS

Column D
List the encounters by provider type. Only include encounters for recipients who were *not* Medicaid-eligible on the date of the encounter.

Column E
List the encounters by provider type. Only include paid encounters for recipients who were Medicaid-eligible on the date of the encounter.

Column F
Enter the sum of Columns D and E.

Line 18
Enter the sum for each column, A through F.

SECTION III — CHARGE INFORMATION

Line 19
Enter the total FQHC charges for services provided to Medicaid recipients and to all patients, including Medicaid recipients. The charges are defined as the usual and customary charges for the services provided before any adjustments for sliding fees or discounts. The charge information includes charges for all services whether they are for direct care, incidental to, or support services where charges could be made.

FEDERALLY QUALIFIED HEALTH CENTER DETERMINATION OF OVERHEAD, RATE, AND REIMBURSEMENT; WORKSHEET 3

Worksheet 3 is used to determine the allowable overhead and total cost of FQHC services, to determine the FQHC's rate per encounter, and to determine the amount of reimbursement for the FQHC.

SECTION I — GENERAL INFORMATION
Enter the FQHC's Medicaid provider number and the inclusive dates of this cost report. Indicate whether the reported expenses are estimated or from the audited trial balance.

SECTION II — DETERMINATION OF OVERHEAD APPLICABLE TO FQHC SERVICES
Section II is used to determine the total costs for the FQHC for the reporting period by using data from Worksheet 1. A calculation is applied to limit reimbursable overhead costs to 30 percent of the FQHC's total cost of operation. Enter the information for Lines 1 through 11 as requested.

SECTION III — DETERMINATION OF FQHC RATE
Section III is used to determine the FQHC rate per encounter. Enter the information for Lines 12 through 14 as requested.

SECTION IV — DETERMINATION OF TOTAL REIMBURSEMENT
Section IV is used to determine the amount that Medicaid will pay to the FQHC or that the FQHC will pay to Medicaid for the reporting period. All amounts are to be reported on the accrual basis.

Lines 15-17
Enter the information for Lines 15 through 17 as requested.

Lines 18a-18d
Lines 18a through 18d include all amounts that Medicare and Medicaid have paid on a fee-for-service basis for the FQHC services provided to recipients covered by these programs. Enter the information as requested on each line.

Lines 18e and 18f
Lines 18e and 18f include the amounts that the FQHC has received from other third-party payers for the services provided to recipients who are Medicaid-eligible. This includes HMO payments and any other third-party payments that the FQHC has received because of coverage of the recipient. The FQHC is expected to pursue all reasonable collection efforts for collection of third-party liabilities. Enter the information as requested on each line.

Line 18g
Enter the copayment amount that Medicaid-eligible recipients are required to pay for those services that require copayment by Medicaid. The FQHC is expected to pursue reasonable collection efforts for collection of copayments.

Line 19
Enter the sum of Lines 18a through 18g. This is the total payment received by the FQHC for services provided to Medicaid recipients during the reporting period.

Line 20
Enter the difference of Lines 17 and 19. This is the balance due to or from Medicaid.

Line 21
Enter the outstationed eligibility expenses from Worksheet 5, Line 30.

Line 22
Enter the sum of Lines 20 and 21. This is the total balance due.

FEDERALLY QUALIFIED HEALTH CENTER MANAGED CARE INCOME REPORTING; WORKSHEET 4

All FQHCs are required to complete this worksheet if they serve Medicaid recipients enrolled in a state-contracted managed care organization. This worksheet serves as supporting documentation for the Determination of FQHC Overhead, Rate, and Reimbursement worksheet.

SECTION I — GENERAL INFORMATION
Enter the FQHC's Medicaid provider number and the inclusive dates of this cost report.

SECTION II — MANAGED CARE INCOME INFORMATION
Enter the total Medicaid encounters and total dollar amount received for each managed care organization that provides services to Medicaid recipients served by the FQHC.

ADDITIONAL DOCUMENTS
The FQHC must retain all documentation supporting Medicare and Wisconsin Medicaid figures submitted for the FQHC cost report period. The documentation must be made available for review at the time of audit.

FEDERALLY QUALIFIED HEALTH CENTER OUTSTATIONED ELIGIBILITY EXPENSES; WORKSHEET 5

Federally qualified health centers will be reimbursed their costs for eligibility outstationing activities. Only direct costs should be included on this worksheet. Direct costs are those costs incurred specifically for FQHC outstationing and directly and completely attributable to FQHC outstationing. Indirect costs or overhead are not allowable for outstationing activities.

SECTION I — GENERAL INFORMATION
Enter the FQHC's Medicaid provider number and the inclusive dates of this cost report. Indicate whether the reported expenses are estimated or from the audited trial balance.

SECTION II — OUTSTATIONED ELIGIBILITY EXPENSES

Lines 1-13
Lines 1 through 13 are allowable personnel costs of FQHC staff whose costs were included on Worksheet 1. Enter only personnel costs incurred for time when staff were working as outstationed eligibility workers as opposed to any other aspect of clinic services. Time sheets must be available to document all time that staff devote to outstationing activities.

Use the adjustment Column H on Worksheet 1 to adjust out of that worksheet the costs incurred by outstationed eligibility workers.

Lines 14-23
Lines 14 through 23 are allowable costs of personnel hired specifically as outstationed eligibility workers who are not involved in any other aspect of clinic services and therefore not included in Worksheet 1 costs. Enter the information as requested on each line.

Lines 24-28
Lines 24 though 28 are allowable costs of materials, supplies, and other non-personnel items other than those personnel costs reported on lines 1-23. Enter the information as requested on each line.

Line 29
Enter the sum of lines 1 through 28 for each column.

Line 30
Line 30 is the total amount reimbursable for FQHC outstationing activities from lines 1 through 28. Information on line 30 is transferred to Worksheet 3, line 21 to determine the total amount of money owed to the FQHC.

Line 31
Enter the total number of eligibility applications processed during the reporting period.